Fairfax County Government
Health, Dental and Flexible Spending Account Enrollment/Change Form

New employees and employees who are newly eligible for benefits through Fairfax County are encouraged to enroll online at http://www.fairfaxcountybenefits.benelogic.com. New employees who are unable to enroll through the Benelogic system, or current employees who are changing coverage due to a qualifying event, must complete and file this form with the Department of Human Resources in order to enroll in or make changes to your enrollment in Fairfax County's health, dental and flex spending account programs.

Once this form is completed, please send it to the Department of Human Resources at 12000 Government Center Parkway, Suite 270, or fax to 703-802-8795. If you fax the form, remember to keep a copy of your fax machine's transmission report as documentation that we received the form by the deadline. Forms that are received after applicable deadlines will not be accepted.

EMPLOYEE NAME _____ SOCIAL SECURITY OR EIN NUMBER _____ DEPT. _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ E-MAIL _____ HIRE DATE _____

Why I'm submitting this form:

☐ I'm a new employee or I am newly eligible for benefits.

-- or --

☐ I wish to enroll, change or cancel my current enrollment due to the eligible qualifying event listed below.

I may revoke certain prior benefit elections and enter into a new election in the event of certain changes in family status, as stated below, provided this form is received by the Benefits Office within 60 calendar days of the qualifying event.

I understand that the changes in my benefit election must be necessitated by, and consistent with, the change in family status and that the change must be acceptable under the IRS Pre-Tax Regulations. The effective date for an employee or dependent(s) who elects to change coverage under the Plan due to a qualifying event shall be as described in the Benefits Handbook. ***Required documentation that must be submitted for each of the qualified change of status events is listed on page 4.***

Change in Marital Status: (circle event below) ***Date Occurred:***_____
Marriage, Death of Spouse, Divorce, Legal Separation (in states that have "legal" separation), Annulment

Change in Number of Dependents: (circle event below) ***Date Occurred:***_____
Birth, Adoption/Placement for adoption, Obtaining legal guardianship, Death of Dependent, Commencement/Termination of adoption proceedings

Change in Employment Status: (circle event below) ***Date Occurred:***_____
Reduction in Hours: *(for dependent or employee)*
Increase in Hours: *(for dependent or employee)*
Commencement/Termination of Employment: *(dependent only)*
Note: If the change in employment status is for a Fairfax County Government employee, check here ☐

Other: (check) ***Date Occurred:***_____

____ Dependent becomes eligible or is no longer eligible for coverage
____ Moving outside the service area of your HMO
____ Court order requiring a change in coverage
____ Significant changes in the cost or coverage
____ Entitlement to/or involuntary loss of Medicare or Medicaid coverage
____ FMLA leave
____ HIPAA Special Enrollment Rights
____ COBRA election/exhaustion or other involuntary loss of COBRA coverage
____ Change in day care provider, change in cost of day care provider
____ Loss of coverage
____ LWOP or Military Leave

Briefly explain change requested: _____

New employees: complete all applicable sections.
Change due to qualifying events: complete only sections that are changing.

Name (Last, First, MI)	Social Security or EIN Number

Section A. Medical and/or Dental Coverage – *(Select the plan, level of coverage, and tell us about those who should be covered)*

Medical	Individual	2 Party	Family	Dental	Individual	2 Party	Family
☐ BlueChoice POS*	☐	☐	☐	☐ Delta Dental PPO	☐	☐	☐
☐ BluePreferred PPO	☐	☐	☐	☐ Waive Dental	☐	☐	☐
☐ Cigna OAP	☐	☐	☐				
☐ Kaiser HMO*	☐	☐	☐	**ALL MEDICAL PLAN ENROLLMENTS AUTOMATICALLY INCLUDE VISION BENEFITS THROUGH DAVIS VISION**			
☐ Waive medical	*** Choose Primary Care Physician in Enrollment Information Section below**						

Enrollment Information – must be completed for each individual to be covered under health and/or dental coverage

Name (Last, First, MI)	Birthdate	Sex	Primary Care Physician (PCP) Name / ID # (Not for BluePreferred PPO or Cigna OAP)	Social Security or EIN Number	Enroll in Health Plan	Enroll in Dental Plan
Employee					☐	☐
Spouse					☐	☐
Child Relationship:					☐	☐
Child Relationship:					☐	☐
Child Relationship:					☐	☐
Child Relationship:					☐	☐

Note: If adding spouse and/or dependent children, you must forward the marriage certificate and/or birth certificates to Benefits in the Department of Human Resources before your enrollment request will be processed.

To Remove a Dependent	Please remove the dependent listed below from the benefits indicated.		
Dependent to be dropped:	Reason for Dropping	Date Occurred:	Drop from: ☐ Health ☐ Dental ☐ Both health and dental
			☐ Health ☐ Dental ☐ Both health and dental
			☐ Health ☐ Dental ☐ Both health and dental

Coordination of Benefits Information	Will you, your spouse, or any children listed in the enrollment section continue to be covered by another health insurance plan after this one begins? If Yes, complete below: ☐ Yes ☐ No		
Name of Policyholder	Policy#	Insurance Company	Effective Date
Covered Under Policy: ☐ Self ☐ Your Spouse ☐ Your Children			

For Benefits Staff only: Date form received: _____ Date documentation requested: _____

_____ In Prism (date) _____ On Activity Report (date) _____ Mission entered (date) _____ (mission number)

New employees: complete all applicable sections.
Change due to qualifying events: complete only sections that are changing.

Name (Last, First, MI)	Social Security or EIN Number

Section B. Flexible Spending Account Programs

Medical Spending Account

☐ Participate in Medical Spending Account. I wish to contribute $_____ for calendar year 2007.
(insert annual election amount)

☐ I wish to receive the EZ Reimburse Debit Card to use in conjunction with my Medical Spending Account.

☐ Waive or cancel participation in the Medical Spending Account.

Dependent Care Account (day care)

☐ Participate in Dependent Care Account. I wish to contribute $_____ for calendar year 2007.
(insert annual election amount)

☐ Waive or cancel participation in the Dependent Care Account.

To Enroll, Change or Cancel Other Voluntary Benefits	
Group Term Life Insurance Basic coverage of 1x salary paid for in full by the County. Additional coverage for the employee, spouse or dependents may be purchased. Medical evidence may be required after the 60 day initial enrollment period.	Separate enrollment forms required. Download from the benefits page on the County Infoweb or call 703-324-3311
Long Term Disability Provides partial salary replacement in the event you are unable to work. Medical evidence is required after the 60 day initial enrollment period.	Separate enrollment form required. Download from the benefits page on the County Infoweb or call 703-324-3311.
Voluntary Long-Term Care Insurance Medical evidence required after 60-day initial enrollment period.	To request an enrollment packet, contact HR Central at 703-324-3311 or email HRCentral@fairfaxcounty.gov. Participants may view plan information at www.aetna.com/group/FairfaxCounty.com or call 800-537-8521.
Deferred Compensation & Virginia College Savings Plans	Separate enrollment forms required. Download from the benefits page on the County INFOWEB or call 703-324-4995.

Acceptance: I hereby apply or waive coverage on behalf of myself and each eligible dependent. I understand that coverage will be provided according to the terms and conditions of the contract between the insurance carrier(s) and my employer. I understand that I must submit my election within 60 days of becoming eligible and that this coverage is not in effect until my election has been accepted by Human Resources. I also understand that this election is made under the IRS Pre-Tax Rules and Regulations. The effective date for my enrollment as a newly-eligible employee shall be the first of the month after Human Resources receives the completed enrollment. I further understand that I cannot cancel or change this election unless I experience a Change-in-Status or am entitled to a Special Enrollment Right under HIPAA.

I understand that I must notify the Benefits Office in Human Resources within 60 days of any change in status which would cause any of my covered dependents to cease to be eligible for benefits under the County's health, dental or life insurance plans due to the dependent's death or loss of eligibility. If I fail to notify the Benefits Office in Human Resources by filing the appropriate forms, I will be responsible for any claims and/or premiums paid on behalf of any individual who ceased to be eligible for benefits under the policy. It is my responsibility to keep informed of any changes to the plan that might affect my or my dependent(s) eligibility. If I am requesting a change in my benefit election it must be necessitated by, and consistent with, the change in
family status and the change must be acceptable under the IRS Pre-Tax Regulations. The effective date for the change and the documentation that must be submitted are described in the Benefits Summary Handbook.

I also certify that the dependents listed above are eligible to be covered as dependents as described in the Fairfax County Benefits Handbook.

I hereby authorize any physician, hospital or other provider of service to furnish any information, reports or copies of records, related to care or services rendered to me or any of the dependents listed above to the insurance carrier(s) or other third parties who require such information to administer the plan. Such information is to be held confidential. I understand that by completing and signing this enrollment form, I am making a binding election with regard to my benefits and that I am authorizing my employer to make the deductions necessary to pay my share of the cost of coverage. I also authorize subsequent payroll deductions in future plan years unless I notify my employer of a change in my election. See Summary Benefits Handbook for more information.

Employee Signature: _____ Date: _____

For Benefits Staff only: Date form received: _____

_____ In Prism (date) _____ On Activity Report (date) _____ Mission entered (date) _____ (mission number)

Important information:

Special Enrollment Rights: If you are declining coverage in the Medical component of the plan for yourself or your dependents (Including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Benefits Office at 703-324-4917 or E-Mail: HR-Central@fairfaxcounty.gov.

Documentation Required for Change in Family Status Events:

Change in Marital Status: Marriage certificate, divorce decree, death certificate or other appropriate legal documentation

Change in Number of Dependents: Birth certificate; hospital proof-of-birth letter, court order appointing legal guardianship or permanent legal custody, death certificate, or legal adoption papers

Change in Employment Status: Letter from spouse's employer stating the change in employment and date that it occurred, the effective date of the coverage change, the type of coverage (i.e. health and/or stand-alone dental plan), and who is (or was) covered under the plan. If the change of employment status is due to Fairfax County government employment, check box on page 1. No letter is required.

Other:

- *Dependent becomes eligible or is no longer eligible for coverage:* Legal documentation or letter from spouse's employer.
- *Moving outside the service area of your HMO:* Address must be changed for payroll purposes
- *Court order requiring a change in coverage*: Court order changing permanent custody or ordering the County to make a change
- *Significant changes in the cost or coverage:* Documentation from spouse's employer showing the change and effective date
- *Entitlement to/or involuntary loss of Medicare or Medicaid coverage:* Entitlement or cancellation letter from Medicare/Medicaid.
- *FMLA leave:* No documentation required for County employees on FMLA.
- *HIPAA Special Enrollment Rights:* Birth certificate, marriage certificate or other appropriate documentation.
- *COBRA election/exhaustion or other involuntary loss of COBRA coverage:* Letter from COBRA administrator explaining circumstances and effective date.
- *Change in day care provider, change in cost of day care provider:* No additional documentation required; complete requested information on page 1.
- *Loss of coverage:* Letter from spouse's employer (see Change in Employment Status above).
- *LWOP or Military Leave:* No additional documentation is required for County employees.

Print Form

Mail completed form to: Department of Human Resources
12000 Government Center Parkway, Suite 270
Fairfax, Virginia 22035

Or fax to: 703-802-8795

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